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Insurance Committee Public Hearing

Thursday, March 2, 2017

Connecticut Association of Health Plans

Testimony in Opposition to

S.B. No. 876 (RAISED) AN ACT CONCERNING REIMBURSEMENT OF OUT-OF-NETWORK HEALTH CARE PROVIDERS AND LIABILITY FOR CERTAIN UNLAWFUL BILLING AND COLLECTION PRACTICES.

S.B. No. 877 (RAISED) AN ACT AUTHORIZING PREGNANCY AS A QUALIFYING EVENT FOR SPECIAL ENROLLMENT PERIODS.

S.B. No. 879 (RAISED) AN ACT ESTABLISHING STATE MEDICAL LOSS RATIOS FOR INDIVIDUAL HEALTH INSURANCE POLICIES AND GROUP HEALTH INSURANCE POLICIES FOR SMALL EMPLOYERS.

S.B. No. 883 (RAISED) AN ACT REDEFINING MAMMOGRAM AND LIMITING COST-SHARING FOR MAMMOGRAMS AND MAGNETIC RESONANCE IMAGING OF BREASTS.

H.B. No. 7123 (RAISED) AN ACT LIMITING CHANGES TO HEALTH INSURERS' DRUG FORMULARIES.

H.B. No. 7124 (RAISED) AN ACT CONCERNING MAXIMUM ALLOWABLE COST LISTS AND DISCLOSURES BY PHARMACY BENEFIT MANAGERS.

On behalf of the Connecticut Association of Health Plans, we respectfully urge the Committee's rejection of all the bills noted above. Until we have a better understanding of what will emerge from the federal government on the Affordable Care Act (ACA) and the impact that it will have on Medicaid, the Exchange, and the commercial market at-large, it would be unwise to tie Connecticut's hands by inhibiting the state's ability to contain costs and/or restructure benefit designs within the scope of available dollars. Please consider that over 85% of the Exchange's 100,000 members are subsidized and that the Medicaid Expansion population is among the most price sensitive. If federal money for both programs dries up, as is widely expected, current "affordability" concerns will be exacerbated and carriers will need every tool in their toolbox to keep premiums within a price point consumers can afford. In terms of each individual bill listed and the Association's concerns, please see below.

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SB 876 seeks to apply the "greatest of three" reimbursement standard to general out-of-network (OON) hospital providers in the same way PA 15-146 applied the standard to Emergency Room physicians.

Sec. 9 of PA 15- 146

> (3) (A) If emergency services were rendered to an insured by an out-of-network health care provider, such health care provider may bill the health carrier directly and the health carrier shall reimburse such health care provider the greatest of the following amounts: (i) The amount the insured's health care plan would pay for such services if rendered by an in-network health care provider; (ii) the usual, customary and reasonable rate for such services, or (iii) the amount Medicare would reimburse for such services. As used in this subparagraph, "usual, customary and reasonable rate" means the eightieth percentile of all charges for the particular health care service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported in a benchmarking (FAIR Health is the designated entity) database maintained by a nonprofit organization specified by the Insurance Commissioner. Such organization shall not be affiliated with any health carrier.

FAIR Health, the designated benchmark, is inflationary and has had the unintended consequence of incenting ER practice groups to remain out-of-network by increasing their reimbursement rates in reflection of charges that are ten to twenty times the Medicare rate according to one large plan. The Association would argue that the current law needs to be rolled back accordingly. That being said, ER services are unique and the legislature recognized this as such by purposely holding regular OON hospital providers to a carrier's in-network rate under PA 15-146. Expanding the applicability of the FAIR Health statute to general OON hospital docs, as proposed under SB 876, compounds the current problem and rewards the bad behavior of certain practitioner groups - namely anesthesiologists and pathologists - who have been shown to exploit the very same provision in other states at the expense of consumers. Some states, like NJ, are now attempting to roll back such measures because of the negative impact.

If the Committee is interested further modifying this statute to assure that consumers are further protected from "surprise bills" in the areas of lab and pathology specifically, we ask that you consider the attached model act language developed by the National Association of Insurance Commissioners (NAIC). This language was developed after years of review with all stakeholders at the table and is considered a consensus approach which begs the question why alternative language is being floated in various states including Connecticut.

SB 877 would allow a person to enroll in the state's health insurance Exchange upon pregnancy. The open enrollment standards are in effect to prevent people from "gaming" the system - that is enrolling in the Exchange only when they're sick or in need of service. When the incentives align in favor of such behavior,

costs spiral out of control as there's not enough good risk to offset the bad risk. This is not simply theory. The experience has borne out over the course of the ACA and the Obama administration recently began to scale back the number of special enrollment periods for just this reason as you can see below:

Special Enrollment Periods for the Health Insurance Marketplace

Date 2016-05-06

Title Special Enrollment Periods for the Health Insurance Marketplace

Contact press@cms.hhs.gov

Special Enrollment Periods (SEP)

While SEPs provide a critical pathway to coverage for qualified individuals who experience qualifying events and need to enroll in or change qualified health plans (QHPs) outside of the annual open enrollment period, it's equally important to avoid SEPs being misused or abused. As it announced today, HHS is tightening the rules for certain special enrollment periods and making clear that SEPs are only available in six defined and limited types of circumstances.

New rules limit the circumstances in which someone may qualify for the permanent move SEP to ensure consistency with the original purpose of that SEP. An Interim Final Rule with Comment (IFC) published in the Federal Register provides that individuals requesting a "permanent move" SEP must have minimum essential coverage for one or more days in the 60 days preceding the permanent move, unless they were living outside of the United States or in a United State territory prior to the permanent move. This ensures that individuals are not moving for the sole purpose of obtaining health coverage outside of the open enrollment period.

We are also making conforming changes to ensure that individuals who were incarcerated, or were previously in the coverage gap in a non-Medicaid expansion state and have moved and become newly eligible for advance payments of the premium tax credit (both of whom would previously have qualified for the permanent move SEP) may continue to qualify for a special enrollment period. Because these individuals were previously unable to have minimum essential coverage or exempt from having minimum essential coverage prior to the qualifying event that qualifies them for this SEP, we are not requiring that they had prior minimum essential coverage to qualify for an SEP.

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The IFC also removes a January 1, 2017 implementation deadline by which Marketplaces would otherwise have had to provide advance availability of the permanent move SEP and provide a SEP for loss of a dependent, or for no longer being considered a dependent due to divorce, legal separation, or death. Marketplaces can still provide either SEP, but implementation and the timing of that implementation are at the option of the Marketplace.

Finally, clarified in separate guidance that SEPs are only available in six defined and limited types of circumstances: (1) losing other qualifying coverage, (2) changes in household size like marriage or birth, (3) changes in residence, with significant limitations, (4) changes in eligibility for financial help, with significant limitations, (5) defined types of errors made by Marketplaces or plans, and (6) other specific cases like cycling between Medicaid and the Marketplace or leaving Americorps coverage.

Though it has remained controversial, the individual mandate is the linchpin of the ACA by assuring that healthy lives remain in the risk pool. Until an alternative solution is identified and adopted, we cannot afford to undermine the system by allowing additional special enrollment periods. Passage of SB 877 could send Connecticut's Exchange into an immediate tailspin. We urge your opposition.

SB 879 seeks to codify the ACA's Medical Loss Ratio (MLR) standard into Connecticut statute. The MLR requires that health insurance carriers spend ***at least*** 80 or 85%, depending on the group's size, of a premium dollar on medical costs in aggregate. If an insurer does not meet the MLR standard, then then the law requires that they rebate the difference to their enrollees. The bill appears to go one step further, however, and prohibits the inclusion of quality improvement programs under the medical formula as allowed by federal law. ACA provisions are all interconnected whether they be related to reinsurance, risk adjustment, risk corridors, essential health benefits, tax credits, premium subsidies, the individual mandate or MLRs just to name a few. Incorporating one ACA provision over another into statute is like removing one leg of a three-legged stool. The system won't be left standing. It is premature to decide what provisions should or should not be codified into state statute until we know what will be coming down from Washington. We urge your rejection of SB 879.

SB 883 appears to redefine mammograms to include the use of tomosynthesis screening in order to designate tomosynthesis as a preventive measure in accordance with the ACA; and therefore exempt the procedure from any initial cost-sharing like that afforded to regular mammograms. The proposal goes one step further, however, and limits all cost-sharing arrangements to no more than $20 per procedure. Any reduction in cost-sharing simply results in a cost-shift to the premium side of the equation. As the Committee contemplates these types of cost-sharing proposals going forward, we ask that you recognize the policy implications of the corresponding increase in premiums that will result.

HB 7123 seeks to prohibit health insurers from removing any drug from its formulary during a policy term or changing its tier within the formulary during the same period. State law already provides that a carrier must

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provide coverage for a drug if an insured was already using the drug for a chronic illness and the attending health care provider states in writing that the drug is medically necessary. Furthermore, the state has strict standards for the use of step-therapy that includes an override provision and the Department of Insurance is currently in process of promulgating regulations that assure the integrity of formularies after issuing a bulletin HC-113 on the issue last summer. Numerous consumer protections are already in place. To the detriment of consumers, passage of this bill would remove any leverage that health plans have to keep drug prices in check. Consider the overnight price hikes of Sovaldi and EpiPens that dominated the press last year and wreaked havoc with state budgets across the country. These are the perfect cases in point. Removing such drugs from formularies and/or changing their tier status is one of the few ways health carriers can push back on pharmaceutical companies and bring them back to the negotiating table which is to the benefit of policy holders overall. HB 7123 starts the right conversation, but it focuses its lens on the wrong aspect of the system. Insurance costs are merely a reflection of underlying medical costs. We urge your rejection of HB 7123.

HB 7124 seeks to establish standards for MAC (Maximum Allowable Cost) pricing. MAC is a way to reimburse pharmacies for the dispensing of generic drugs. It is separate and aside from the process used in reimbursing for brand names. By definition, MAC is the maximum allowable reimbursement by a PBM for a particular generic drug that is available from multiple manufacturers. Each manufacturer has its own price for the same drug and these prices can differ extensively. For the benefit of consumers, MAC pricing standardizes the reimbursement amount for identical products offered by various sources and as a result provides an incentive for pharmacies to negotiate more competitively around generic rates. To do so, pharmacies often join buying groups and/or Pharmacy Services Administration Organizations (PSAOs) as a way to earn discounts and rebates from preferred suppliers. A typical PSAO may represent thousands of pharmacies, giving these groups access to pooled purchasing power, negotiating advantages, and contracting strategies.

While the Association worked in good faith on this proposal a few years back, since then the landscape has changed dramatically not just in terms of the ACA, but also by virtue of a recent court decision (PCMA v. Gerhart Decision) just handed down in Iowa on MAC pricing that may preclude action on this matter.

On January 11, 2017, a three-judge panel of the Eighth Circuit Court of Appeals struck down Iowa's 2014 MAC/transparency law in its entirety, in an opinion that essentially precludes ***any*** state regulation of MAC. In its opinion, the Court said that under ERISA, states cannot dictate how plans structure and pay for plan benefits, including prescription drugs.
On January 26, 2017, the State of Iowa asked the full Eighth Circuit to review the three-judge panel decision. The Court's decision to accept such review is currently pending. Until the matter is finalized it would be ill-advised for Connecticut to move forward with this legislation.

As you know from previous Association testimony, the price of pharmaceuticals is a major cost driver in the

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escalation of premiums. Just this week, it was reported at Connecticut's Exchange Board meeting that pharmacy trend is running at 11.5 %. This is not the year to modify policy impacting prescription drug pricing. We urge your rejection.

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